[Reprintedfor the Author from the *British Medical Journal*, February 11th, 1888.]

Read.

THE MANAGEMENT OF ANTERIOR AND POSTERIOR DISPLACEMENTS OF THE UTERUS.[1]

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I AM fully alive to the responsibility which anyone incurs in venturing to lay down definite lines of treatment concerning anterior and posterior displacements of the uterus, for I believe I am safe in saying that upon no subject in gynæcology has greater diversity of opinion existed, and upon none have more opinions been expressed with equal confidence. This subject has been the bone of contention between different schools of gynæcology for many years. That this should be the case is easy of explanation, and that for various reasons: 1. Because many teachers and practitioners have regarded the conditions as merely mechanical, and directed their treatment accordingly; 2. Others have considered the conditions as the result of inflammatory action, and their treatment has been in strict accordance with their views; 3. Others, perhaps the largest class of all, have regarded symptoms alone, and treated the conditions empirically; 4. It must be further kept in view how frequent are deviations in the position of the uterus, and how prone we are to seize any seemingly pathological condition as an explanation of symptoms and to treat it vigorously when the condition is all the time only a coincidence, not a cause.

Now, in venturing to offer to you a sketch of the treatment of the displacements under consideration, I would have it clearly understood that anterior and posterior displacements occur in two great groups:

1. Displacements in virgins or nulliparæ.
2. Displacements in parous women.

In regard to the first class I am inclined to look upon them, speaking generally, as being congenital conditions; the anteflexion being in the direction of non-development, and the retroflexion in the direction of deformity. These conditions in virgins are not infrequently associated with diseased conditions of the annexa, and when they are it is the inflammatory condition of the annexa which requires treatment, and not the congenital deformity or non-development. A well-marked illustration of this came under my observation lately when a patient had for eight years been under treatment with pessaries for an anteflexed undeveloped uterus. Her distress was so great and persistent that I removed the ovaries, which were extensively diseased, and the woman has had comfort ever since, the uterus still remaining anteflexed. The progress which gynæcology has made in recent years in advancing our knowledge of the uterine annexa has shown conclusively that many cases of pain and dysmenorrhœa

[1] Read in the Section of Obstetric Medicine at the Annual Meeting of the British Medical Association held in Dublin, August, 1887.

which were formerly attributed to uterine displacements are due entirely to conditions of the ovaries and tubes independently of a concurrent displacement which may mean nothing. Deviations in the position of the uterus of minor degree give rise in the single woman to no symptoms, and require, therefore, no treatment. Marked versions uncomplicated with some pathological condition, such as a fibroid, are rare in single women, and when uncomplicated give rise to very slight symptoms, and need no mechanical interference. When the flexion backward or forward is very acute, I do not deny that it may be associated with severe dysmenorrhœa. Even admitting that these displacements in virgins give rise to some discomfort, what treatment is at our disposal? Vaginal pessaries are seldom if ever curative, and intra-uterine pessaries are surrounded with such risk in the direction of inflammation, hæmatocele, and ovaritis, that so far as I am concerned I have discarded their use altogether. Let it be distinctly understood that I by no means wish to say that, in the hands of an experienced gynæcologist, there are not cases, especially of retroflexion in virgins, in which the pressure symptoms from hypertrophy and enlargement are to be remedied in no other way than by stem pessaries, but these cases are, so far as my experi- experience goes, extremely few, and do not fail to be discussed in a general view of the case. It is only fair to say that intra-uterine stem pessaries have within my knowledge, in some exceptional cases, rendered benefit; but on looking back over an experience of nearly twenty years I mean to say that I have known them do more harm than good, and as a teacher of gynæcology I have found it my duty to warn students and practitioners against their use.

But the question naturally arises as to the cure of dysmenorrhœa, which unquestionably is often associated with, although not necessarily dependent on, these displacements. Is no mechanical treatment to be adopted? Now, upon this point there seems to be too great a tendency to local interference for dysmenorrhœa in virgins. I should withhold local treatment altogether unless its severity be such that, after all other means failed, it interferes with a rich woman's social engagements or a poor woman's means of livelihood, for it must always be kept in view that dysmenorrhœa is but a relative term. When, however, local examination and treatment become necessary, then vaginal pessaries are of little avail, and intra-uterine stem pessaries are unsafe. Dilatation of the cervix with a dilator bougie or an occasional passage of the sound, with the persistent use of the hot vaginal douche, will often effect a cure both effectively and safely. Here I must enter a caveat against the indiscriminate use of the sound and dilators, unless accompanied by careful precautions; and these are (1) that there be no recent or remote peri-uterine inflammation; (2) that the greatest care be taken as to the perfect cleanliness of the instrument.

Much as we owe to the sound, yet I feel sure that its indiscriminate and routine use has been a fertile source of uterine mischief.

In a word, then, in unmarried women and nulliparæ, with some exceptions too few to affect the general statement (the conditions being usually congenital), vaginal pessaries are of no avail, and intra-uterine are always dangerous and usually hurtful. When aggravated dysmenorrhœa is concurrent with a simple displacement, then the use of a sound, bougie, or dilator, along with hot water, will often effect a cure. If there be the least pathological condition to be found in the annexa, there should be no mechanical treatment, but only the hot douche.

With regard to parous women, the case stands differently. In them, unlike the others, the displacements are usually, if not always, acquired. In the case of anteflexion and anteversion, which in parous women are so often induced by various forms of peri- and parametritis, and by inflammation of the utero-sacral ligaments specially, mechanical treatment in the shape of pessaries is seldom indicated. The sphere for anteversion and anteflexion pessaries in parous women—if, indeed, they have a sphere at all—must be when the displacement does not depend upon any inflammatory condition outside the uterus, but is solely due to an increase in its weight. Even in such cases, which are rare, the trouble and annoyance to both physician and patient attending their use is more than sufficient to outweigh their temporary comfort. Of stem pessaries in forward displacements of the uterus in parous women, I have no experience, and I have yet to see the case in which I consider their use desirable. The majority of these anterior displacements give rise to very unimportant symptoms. When they do, the symptoms are due to some inflammatory products outside the uterus, and the treatment is to be directed to its removal (1) by the hot vaginal douche; (2) by blisters; (3) by iodine applied to the vaginal roof; and (4) by small doses of iodide of potassium and perchloride of mercury internally. Sometimes a soft glycerine ring pessary, by relieving tension and elevating, may do good, but as a rule even this is contra-indicated.

Coming now to posterior displacements in parous women, namely, retroversion and retroflexion, we are bound to recognise the fact that they are specially prone to arise mechanically. This will appear obvious if we consider the frequency with which these conditions occur after pregnancy as a result of imperfect involution, dorsal decubitus, increase in weight, and too early rising.

The origin of these parous posterior displacements being usually, though not always, mechanical, and the symptoms to which they give rise, such as sterility, leucorrhœa, menorrhagia, and pressure, to a greater or lesser extent being well recognised, their treatment must be mainly based on mechanical principles.

1. Tone must be given to the uterus by the use of ergot and hot-water douching.

2. The uterus must be carefully adjusted in one of several ways: (*a*) by pressing up the fundus; (*b*) by pressing back the cervix; (*c*) by the genu-pectoral position; (*d*) by dragging down the lip of the cervix with a volsella; and lastly, by the sound. In any case, accurate and careful reposition of the uterus in any of the ways I have mentioned is essential. I place the sound last because I really think that the bimanual replacement of the uterus is the safest and most thorough, and because the introduction of any body into the cavum uteri is always to be avoided when practicable.

3. The uterus must be retained in position by a pessary. In the case of a well-marked retroversion, a well-adjusted Hodge, or some of its many modifications, will be found to act efficiently, whereas in the case of a well-marked retroflexion the ordinary ring pessary will act better than the Hodge. The Hodge in such circumstances is inapplicable because of the difficulty of adjusting it so as to act with much advantage on the fundus, and it is apt to get into the sulcus between the cervix and uterus, and so aggravate the condition it was intended to cure. In such cases the ordinary ring pessary, by elevating the whole uterus, will give most relief.

In some aggravated cases of acute flexion with hypertrophy, stem pessaries may, under exceptional circumstances, be required, but this must always be regarded as a *dernier ressort.*

In that class of cases—which is exceedingly frequent—where there is some degree of flexion and version combined, the Hodge will most frequently meet the requirements of the case. Should there be any adhesions or any ovarian prolapse the soft india-rubber glycerine ring will be most generally serviceable.

ON THE

INDICATIONS FOR AND METHOD OF WASHING OUT THE PUERPERAL UTERUS.

BY

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(*Read before the Edinburgh Obstetrical Society, 9th March* 1887.)

PRINTED BY OLIVER AND BOYD, EDINBURGH.

MDCCCLXXXVII.

REPRINTED FROM THE EDINBURGH MEDICAL JOURNAL FOR MAY 1887.

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INDICATIONS FOR AND METHOD OF WASHING OUT THE PUERPERAL UTERUS.

Introduction.—Perhaps I owe an apology to this Society for bringing up the subject of my paper to-night. To many of you the subject is well known, but my reasons for venturing to occupy your time with it are these:—1. Because the subject receives but scant attention in our text-books; 2. Because men seem to have a timidity and dread in dealing with the puerperal organ; and 3. Because there is no point upon which a consultant's opinion is more frequently sought.

That many lives have been sacrificed from want of due attention to the antiseptic washing out of the post-partum and post-abortum uterus there can be no doubt, and there is as little question that ignorance of the proper indications for and method of washing out have been accompanied by serious, even fatal results.

It may be that I ought to have reserved the remarks which follow for a less learned, less critical audience than the present; but in the hope that they may be of advantage to some of the busy Fellows of our Society, I beg to submit them to you.

At the outset, let me say that no one deprecates more than I do any manual interference with the parturient or puerperal uterus that is not absolutely necessary. Every examination made during labour is a possible source of infection, and still more so any opening up of the genital canal after labour develops a fresh source for the introduction of septic material in the still fresh wounds. Equally do I discourage the meddlesome interference of nurses with douches, syringes, and so forth, as routine in every case of labour, at least in private practice. I am very sure that the less the vagina is opened up the better will it be for the patient. If this be true of the vagina, still more is it so with regard to the opening up and interfering with the uterine cavity. Still there are conditions where interference with the caverni uteri becomes a pressing necessity. Let me try to formulate the circumstances under which antiseptic washing out of the uterine cavity is indicated.

Indications.—1. Where, with localized tenderness over the uterus, there is a high pulse and temperature, and a fœtid discharge. It is to be observed that the discharge must be fœtid *from the uterus.* In order to decide this question, it is essential to wash out the vagina with an antiseptic wash—inodorous, such as corrosive sublimate—and then putting the finger up and into the cervix to decide whether it is fœtid or not. As I shall have occasion to point out in the sequel, all first washings out should be performed under chloroform, therefore I always explore the cavity of the uterus with the finger. I need not here refer to the ease with which this can be performed, at least during the first week of the puerperium. Even at a long period after labour, the carbolized fingers can be comparatively easily introduced. In most cases some morbid product will be found, and in all cases the necessary dilatation of the cervix will much facilitate the process of washing out.

2. Where, with a high pulse and temperature, there is any question as to the absolute complete delivery of the placenta; and in this connexion it is impossible to emphasise too strongly the importance of examining closely the placenta after delivery, whether it be expressed, extracted, or delivered spontaneously. Such care will often eliminate at once any possible cause of infection.

3. Where portions of membrane have been retained *in utero,* and give rise to increase in pulse and temperature. Here, however, let me say it is possible to do harm in endeavouring to remove the membranes completely at the time of delivery. It is much better to leave a portion of membrane than to open up the genital canal in search for a small piece.

4. After the birth of a putrid fœtus.

5. Where the uterus remains abnormally large after labour, and where, as a result, owing to the presence of decomposing clot, symptoms of septic infection develop themselves. In such cases washing out ought to be accompanied by the introduction of the finger within the uterus, and in all such cases quinine ought to be administered in large doses.

6. In cases where, late on in the puerperium, symptoms of septicæmia develop themselves.

7. In those somewhat rare, yet well-recognised cases where, from acute flexion of the uterus, the lochia are retained and decompose.

8. In some cases of imperfect abortion and premature labour, and in all cases where the uterus, under such circumstances, has been curetted.

9. In all cases where the hand has been introduced—say in cases of post-partum hæmorrhage, adherent placenta, or uterine hydatids—washing out the uterus with hot antiseptic water is the recognised treatment.

Rationale.—What is the rationale of washing out the puerperal uterus in septicæmia? It seems at first sight open to doubt how far washing out the uterine cavity can prove effective in checking septicæmia if rapidly multiplying microbes have already passed into the system.

This point was alluded to during the interesting discussion which took place last session on the relation of micro-organisms to puerperal fever, viz., that micro-organisms require the condition of rest for their development. They do not multiply in the circulating blood. Dr Freeland Barbour neatly and forcibly put it thus:—"That in those cases the toxic material does not multiply in the blood, but is generated in the uterus alone, from which it is served out into the system and eliminated by the excreting organs. The relation might be illustrated from the gas supply of a city, in which the gas is, of course, produced at the retorts at the central work, and is simply served through the pipes and eliminated at the burners. By washing out the uterus we put out the retorts and stop further production, the elimination of the poison being only a question of time." Now, let me here say, that the value of washing out the uterus is confined to those cases where the septic material is developed in and confined to the uterine cavity. Where the development of the toxic material has gone beyond this, or where the septicæmia is developed originally outside the uterus altogether, obviously washing out the uterus will be of no avail.

Method.—As far as my experience goes, a good deal of misunderstanding exists as to the proper method of carrying out this operation. The following points seem to me worthy of attention:—

1. The patient ought to be so placed that her shoulders are raised while her pelvis is depressed. This is just the converse of what is required in gynæcological douching—the object being to prevent any quantity of the lotion remaining *in utero* by giving it free escape. Two methods of accomplishing this can be adopted—either by placing the patient on her back in the bed with a douche pan placed underneath her buttocks, or else that she be placed transversely across the bed with her hips depending across its edge. The latter seems to me the more convenient and satisfactory.

2. Care should be taken that the os uteri be patent, so as to allow a free escape of fluid. Frequently, however, it is closed, and when such is the case recourse must be had to the grooved glass tubes, or to the double channelled catheter. The glass tubes are the more generally applicable, for one amongst other reasons, as the sublimate solution corrodes a metal instrument, and the eye of the catheter readily gets blocked.

3. The continuous douche is preferable to the ordinary syringe; but inasmuch as the douche can is not always at hand, the syringe will be the most usually available.

4. The tube should be carried right up to the fundus uteri, and if the syringe be employed it ought to be used slowly, steadily, and without jerking.

5. The fluid ought to be injected at a temperature of about 115° F., and continued until it return quite clear and sweet, or at most mixed with a little pure blood. Special attention ought to be paid to having the temperature high, so as to induce uterine contraction, and that for two reasons—(1), Because the uterus in these cases is usually atonic; and (2), specially in those cases where corrosive sublimate is employed, so as to insure that none of the salt remains in the uterus to act as a poison.

6. A point of essential importance is that the fundus uteri should be grasped by the hand of an assistant in such a manner that the thumb and middle finger compress each Fallopian tube, so that at one and the same time the fluid may be squeezed out of the uterus, brought intimately in contact with the whole uterine surface, and prevented passing above the Fallopian tube. It must be borne in mind that the puerperal uterus is frequently rotated on its transverse axis, and therefore must be grasped obliquely.

7. I would strongly urge that the patient should be placed under chloroform for at least the first washing out. I am confident that many cases suffer from the want of this precaution; because, owing to the tenderness of the parts, it is impossible to manipulate the uterus and instrument properly, the tube being not carried beyond the os internum, if so far. And, besides, it gives the operator the opportunity of exploring the cavum uteri, if need be; and I may add, it is usually best to do so.

Form of Antiseptics.—The only two forms of antiseptics which are sufficiently reliable are either carbolic acid or corrosive sublimate; and of the two, corrosive sublimate seems, with proper and careful precautions, to be the form upon which most dependence can be placed. It is not, however, without its objections. The ease with which it is absorbed, and the small quantity required to produce its toxic effects, must be kept strictly in view in using it. Not only is it readily absorbed by the uterus, but even when used for the vagina alone its poisonous effects become manifest; and there are not wanting numerous cases where serious corrosive sublimate poisoning has taken place, some of which have ended fatally.

Keller has shown that in most cases mercury can be detected in the urine after irrigation of the uterus or vagina with sublimate solution of the strength of 1 in 1000 or 1 in 2000, but, of course, most frequently after washing out the uterine cavity. I have myself been able to detect it in my hospital cases when the solution has been much weaker, and in one case where the vagina alone was syringed with a solution of 1 in 3000 before labour, I found traces in the urine.

Keller records a fatal case of mercurial poisoning. Von Horff

in his paper reports thirteen cases of serious corrosive sublimate poisoning. Partridge records a death after two irrigations of the uterine cavity with a solution of 1 in 2000. Thorn records three cases of poisoning, two of which were fatal. In each of the cases the strength of the solution used was 1 in 1000. In the *first* case the uterine cavity was washed out after the expulsion of a putrid fœtus. Immediately after there was collapse, scanty flow of urine on the third day, diarrhœa, albuminuria, salivation, and ultimately recovery. The *second* case the uterine cavity was washed out, after the expulsion of a three months' fœtus, at the sixth month. Death occurred on the ninth day, with symptoms of mercurial poisoning. The *third* case was one where the vagina alone was irrigated, and the patient died on the ninth day.[1] The cause of these serious, sometimes fatal, symptoms obviously is to be found in the strength of the solution used, none of those in whom serious symptoms developed themselves being weaker than 1 in 2000, and some of them as strong as 1 in 1000.

In using corrosive sublimate care must be taken that the solution be not stronger than 1 in 4000 or 1 in 5000. The numerous experiments of Koch, Tarnier, and others, have shown that this is strong enough for all practical purposes. There are, however, two conditions in which it is of the utmost importance to be careful in the use of corrosive sublimate, and these are in profound anæmia, and where there is any kidney disease. In both of those cases carbolic acid will be found a more suitable and safe antiseptic.

Safety of Operation.—Considerable misunderstanding has existed, and still exists, among practitioners as to the risk attending the operation. A good deal of this is no doubt due to the fact that men compare the risk of this operation with the risk of injecting strong escharotic solutions, for therapeutic purposes, into the non-puerperal uterus,—a method of treatment for long advocated and adopted by the French school. The risks of this latter operation are so great, in my opinion, as to render its adoption entirely unwarranted. But then the two cases are by no means parallel, and for these reasons:—In the non-puerperal uterus (1), the fluid introduced is a strong caustic; (2), the os uteri is closed; (3), the fluid is kept long in contact with the uterine wall; (4), there is no means of pressing on the fundus; (5), there is nothing to prevent, but everything to encourage, acute inflammation, as well as the passage of the fluid along the Fallopian tubes into the peritoneal cavity, whereas the washing out of the puerperal uterus with a weak antiseptic solution is practically without danger, provided it is done in the way and with the precautions that I have just described.

Contraindications.—To the uniform employment of intrauterine douching there are, of course, contraindications, or rather I should

[1] In my own experience, both at hospital and in private, I have met with frequent cases of corrosive sublimate poisoning in a minor degree.

say conditions, which render the employment of it impracticable; such are the presence of perimetric or parametric inflammation, with or without deposit. In those cases intrauterine douching will not only do no good, but it will probably render matters considerably worse. It will do no good, because the source of infection has passed from the uterus into the veins in the broad ligament, or into the lymphatics, and hence the washing out will not reach the source of the evil, and it may make matters worse, for it will increase the inflammation in the surrounding tissues.

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